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REFORM Update

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The IRS recently issued Notice 2013-54 clarifying the effect of the Affordable Care Act (ACA) on account-based programs. The Department of Labor's Technical Release 2013-03, issued at the same time, is substantially identical to the IRS guidance on account-based plans. The guidance explains the effects of health care reform on the following:

1. Health reimbursement accounts (HRAs), including HRAs integrated with group health plans
2. Employer payment plans
3. Certain medical flexible spending accounts

Employers are asking how several aspects of health care reform will apply to these accounts. The guidance explains two market reform requirements:

- *Annual dollar limits on essential health benefits*. As of the first day of the first plan year on or after January 1, 2014, a group health plan will not be allowed to set an annual dollar limit on essential health benefits. Annual dollar limits are permitted, however, on benefits that are not considered essential health benefits.
- *Expansion of preventive services with no cost-sharing (non-grandfathered plans).* Group health plans now must cover specific preventive care services in-network with no member cost-sharing.

The regulations also briefly discuss employee assistance programs (EAPs). The Departments intend to consider EAPs as excepted benefits so long as they do not provide significant medical care or treatment benefits. Thus most EAPs will **not** be subject to the ACA market reforms. For 2014, employers can consider their EAPs as excepted benefits so long as they do not provide significant medical benefits.

The guidance discusses whether the law will permit the following arrangements after January 1, 2014.

Health Reimbursement Accounts (HRAs)

An HRA is an employer-funded account that reimburses employees, their spouses and dependent children under age 27 for Section 213(d) covered medical expenses.

These accounts set a maximum dollar amount for reimbursements during the plan year. The plan dictates how employees can use funds remaining at the end of the year. Many employers allow some or all of the HRA balance to roll over into the next plan year. Reimbursements are tax-favored for both employers and employees.

There have been questions about how the ACA affects HRAs, since they are considered to be group health plans. Guidance previously issued indicates the following:

- Because of the ACA's ban on annual dollar limits, an employer-sponsored HRA cannot be integrated with individual market coverage or with individual policies purchased under an employer payment plan. HRAs used to obtain individual market coverage will not comply with the 2014 annual dollar limit restriction. However, this restriction does not apply to **retiree-only** health plans. The ACA will still permit retiree-only HRA plans after 2014.
- An employer-sponsored HRA integrated with an employer-sponsored group health plan complies with the ban on annual dollar limits if the underlying group health plan complies. An employee has to enroll in the underlying health plan for the HRA amounts to be considered integrated. However, if the employer provides an HRA to someone not enrolled in the underlying health plan, then in most cases, the plan will not comply because of the ban on annual dollar limits. The new regulations include more details on this situation.
- Employees can use funds that have been rolled over in a standalone HRA in 2014. The amounts credited for 2013 must meet the terms of the plan in effect on January 1, 2013. If the plan did not define contributions for 2013, the 2013 contribution cannot exceed the amounts credited in 2012. The ACA permits a standalone HRA after 2014, but only to spend down any rollover contributions. No new contributions can be added after 2014.

The new guidance offers more detail on how the 2014 market reforms affect HRAs:

- It is clear that HRAs integrated with ***individual*** health policies do not comply because of the ban on annual dollar limits. This guidance clarifies that any other group health plan cannot be integrated with ***individual*** health coverage to meet the annual dollar limit restriction.
- HRAs meet the preventive services requirement if the HRA is integrated with a comprehensive group health plan that complies with this requirement.
- Similarly, HRAs cannot be integrated with ***individual*** health policies to meet the preventive services requirement.

The guidance offers two methods to help determine whether an HRA and the employer-sponsored group health plan are integrated. These two methods are particularly important for employers that want to offer HRA coverage to employees that waive coverage under their medical plan.

1. **Minimum Value Not Required**

   An HRA is integrated with a group health plan as far as the ban on annual dollar limits and the preventive services requirement if:

   a) The employer offers a group health plan (other than the HRA) that does not consist solely of excepted benefits.

b) The employee receiving the HRA is actually enrolled in a group health plan (other than an HRA) that does not consist solely of excepted benefits, regardless of whether the employer sponsors the plan.

c) Employers may fund an HRA for employees that enroll in a comprehensive health plan with a different employer. For example, the employer may choose to fund an HRA for employees who waive coverage because they are covered by a spouse's group health plan.

d) The HRA reimburses only the following expenses:

   1) Copayments
   2) Coinsurance
   3) Deductibles
   4) Premiums under non-HRA group coverage, as well as IRC Section 213(d) medical care not considered an essential health benefit

e) Under the terms of the HRA, at least once a year an employee or former employee can choose to opt out or waive future HRA reimbursements permanently. When employment ends, employees can forfeit the HRA balance or permanently waive HRA reimbursements. The opt-out feature is necessary because HRA coverage is considered minimum essential coverage. Anyone who has an HRA will not qualify for tax credits in the Marketplace.

2. Minimum Value Required

An HRA not limited to reimbursements, as required under the integration method explained above, may still considered integrated with a group health plan as far as the ban on annual dollar limits and the preventive services requirement if:

a) The employer offers a group health plan that provides minimum value (60% value).

b) The employee receiving the HRA is enrolled in a group health plan that provides minimum value, regardless of whether the employer sponsors the group health plan.

c) The HRA is available only to employees who are enrolled in non-HRA, minimum-value, employer-sponsored group coverage. The employer may also offer the HRA to employees who do not enroll in the employer plan but are covered by another group health plan (for example, a spouse's plan). Employees covered under another employers' group health plan will need to affirm that the plan offers minimum value coverage.

d) Under the terms of the HRA, at least once a year an employee or former employee can choose to opt out or waive future HRA reimbursements permanently. When employment ends, employees can forfeit HRA balances or permanently waive reimbursements. The opt-out feature is necessary because HRA coverage is considered minimum essential coverage. Anyone who has an HRA will not qualify for tax credits in the Marketplace.

The following examples illustrate how to determine whether an HRA is integrated with the group health plan.

Minimum Value Not Required: Employer A sponsors a group health plan and an HRA for employees. The HRA is available to employees who enroll in the employer's group health plan, and also to employees enrolled in non-HRA group health coverage through a family member. Employer A limits reimbursements to copayments, coinsurance, deductibles and premiums under group coverage, as well as to IRC Section 213(d) medical care that does not constitute essential health benefits. Under the terms of Employer A's HRA, employees can permanently opt out or waive future reimbursements from the HRA at least once a year or when their employment ends.

Employer A employs Employee X, who chooses to enroll in non-HRA group coverage sponsored by Employer B, the spouse's employer. Employers A and B are not related employers. Employee X certifies that he is covered under Employer B's non-HRA group health plan. Employee X seeks reimbursement only for copayments, coinsurance, deductibles and premiums under non-HRA group coverage, as well as for IRC Section 213(d) medical care that does not constitute essential health benefits

Employer A's HRA is considered integrated with Employer B's non-group HRA coverage as far as the annual dollar limit restriction and preventive services requirement.

Minimum Value Required: Employer A sponsors a group health plan and an HRA. The HRA is available to employees who are either enrolled in the employer's group health plan or enrolled in a non-HRA ***minimum-value*** group health plan through a family member. Under the terms of Employer A's HRA, employees can permanently opt out or waive future reimbursements from the HRA at least once a year or when their employment ends.

Employer A employs Employee X who chooses to enroll in a non-HRA ***minimum-value*** group health plan sponsored by Employer B, the spouse's employer. Employers A and B are not related employers. Employee X certifies that he is covered under Employer B's non-HRA ***minimum-value*** group health plan.

Employer A's HRA is considered integrated with Employer B's non-group HRA ***minimum-value*** coverage as far as the annual dollar limits and preventive care service requirements.

Both of these examples clarify when an HRA can be considered integrated to meet the annual dollar limit ban and preventive services requirement. The key in both examples is that the employer does not limit HRA eligibility to employees covered by the employer's comprehensive group health plan. If other employer group health plans cover the employee, it will be important to make sure the other employer coverage can be considered integrated.

The guidance also discusses retiree-only HRAs. These accounts do not need to comply with the market reform requirements because they cover only retirees, not active employees. However, they are still considered employer-sponsored health plans. These plans will constitute minimum essential coverage under health care reform. Retirees have minimum essential coverage during any months **when they have HRA funds available**. Retirees with minimum essential coverage are not eligible for premium tax credits in the Marketplace when they purchase individual coverage.

Further, the guidance discusses what happens to HRA account balances if an employee loses integrated group health plan and HRA coverage. If the employee can access account balances after group health coverage ends, the termination will not affect whether the HRA meets the annual dollar limits or preventive services requirements. If, however, the employee continues to use the accumulated HRA funds, then the HRA coverage is viewed as minimum essential coverage. In this case, an individual may not be able to obtain subsidized coverage in the Marketplace.

Employer Payment Plans

Employer payment plans allow employers to reimburse employees' premiums for individual health plan coverage. The employer's reimbursements are considered tax-favored. These plans cannot be part of a Section 125 plan that permits a choice between cash and benefits.

Employer payment plans are not permitted in 2014 because they will fail to meet the ban on annual dollar limits and the requirement to cover specified preventive services on a first-dollar basis.

For taxable years beginning after December 31, 2013, the term "qualified benefit" under Section 125 will not include any qualified health plan (QHP) offered in the Marketplace. This only applies to individual QHPs, not to group health coverage that the employer may purchase in the Marketplace. If the Section 125 plan operates on a plan year (not calendar year) as of September 2013, then the QHPs remain a qualified benefit under a Section 125 until the first day of the first plan year occurring on or after January 1, 2014.

Certain Medical Flexible Spending Accounts

Section 125 of the Internal Revenue Code governs medical flexible spending accounts. Employers offer medical flexible spending to allow employees to set aside pre-tax funds to pay for medical expenses the health plan doesn't cover.

This notice also discusses how medical flexible spending accounts comply with market reforms if they are not considered "excepted benefits." FSAs are considered excepted benefits when:

1. The employer offers non-excepted health plan coverage to all employees eligible for the medical FSA.
2. The maximum benefit payable to any participant is no more than twice the participant's election for the medical FSA for the year or, if it is greater, it does not exceed $500 plus the amount of the participant's salary reduction for the medical FSA.

On the surface, medical FSAs that are **not** considered excepted benefits will not meet the market reforms. The regulations regarding the annual dollar restriction make an exception for medical FSAs offered through a Section 125 plan. However, the expanded coverage for preventive services would still apply to a non-excepted medical FSA. The government understands this is an issue, but did not include any information about excluding the preventive services requirement from a non-excepted medical FSA. The government may resolve this situation, but as it stands today, it appears non-excepted medical FSAs will not be permitted in 2014.

In general, most employers with non-excepted medical FSAs have them because they cover a segment of employees not offered group health plan coverage by the employer. Employers in this situation may want to reconsider offering medical FSAs **only** to employees who are eligible for their medical plan.

Concluding Thoughts

These regulations eliminate several methods that employers could consider to offer tax-favored dollars to employees purchasing individual coverage in the Marketplace:

- Standalone HRAs will not comply with the market reform requirements that ban annual dollar limits and require preventive services coverage. An employer cannot offer a standalone HRA to provide tax-favored funds for purchasing individual coverage in the Marketplace. However, the IRS will allow employees to spend down balances in a standalone HRA.
- Individual QHPs will not be considered "qualified benefits" under a Section 125 plan. Therefore, employers cannot allow employees to make pre-tax contributions to pay for individual QHPs in the Marketplace.
- Separate employer payment plans that allowed employers to pay for individual health coverage for employees with pre-tax dollars will not be permitted in 2014. These plans will not meet the ban on annual dollar limits and the preventive services coverage requirements under health care reform.

Finally, it appears that a non-excepted medical FSAs will not be permitted in 2014 because it does not meet the preventive services requirement. Unless the government issues additional guidance on this situation, a non-excepted medical FSA will fail a key aspect of health care reform.